

# MEDICAL HISTORY

Please circle the correct response (Yes, No or Don't know); answer all questions.  
The following questions are for our records only and will be considered confidential information.

Patient's Last Name	First	Initial
		Date of Birth

Do you have or have you had any of the following:

## CARDIOVASCULAR AND BLOOD DISORDERS

- |   |     |    |            |
|---|-----|----|------------|
| 1. Rheumatic fever?.....  | Yes | No | Don't know |
| 2. Hypertension (high blood pressure)?.....                                 | Yes | No | Don't know |
| 3. Heart attack, irregular heart rate, damaged heart valves or angina?..... | Yes | No | Don't know |
| 4. Stroke?.....   | Yes | No | Don't know |
| 5. Heart murmur?.....   | Yes | No | Don't know |
| 6. Chest pain or shortness of breath on exertion?.....                      | Yes | No | Don't know |
| 7. Swollen ankles?.....   | Yes | No | Don't know |
| 8. Blood disorders such as anemia or hemophilia?.....                       | Yes | No | Don't know |
| 9. Frequent nosebleeds, increased bruising or bleeding?.....                | Yes | No | Don't know |

## ALLERGIES AND IMMUNE SYSTEM

- |  |     |    |            |
|--|-----|----|------------|
| 10. Asthma, tuberculosis or hay fever?.....                                | Yes | No | Don't know |
| 11. Hives or a skin rash?.....   | Yes | No | Don't know |
| 12. Have you ever had a reaction to any drugs?.....<br>If yes which drugs? | Yes | No | Don't know |
| <hr/>  |     |    |            |
| 13. Do you have any allergies?.....  | Yes | No | Don't know |
| 14. Are you immunosuppressed (subject to frequent infections)?.....        | Yes | No | Don't know |
| 15. Have you been told you have AIDS, ARC or an HIV positive test?.....    | Yes | No | Don't know |

## GASTROINTESTINAL

- |  |     |    |            |
|--|-----|----|------------|
| 16. Ulcers, stomach or intestinal problems?..... | Yes | No | Don't know |
| 17. Hepatitis (jaundice) or liver disease?.....  | Yes | No | Don't know |

## ENDOCRINE

- |  |     |    |            |
|--|-----|----|------------|
| 18. Diabetes (high blood sugar)?.....                                    | Yes | No | Don't know |
| 19. Frequent urination (six times/day), kidney disease or dialysis?..... | Yes | No | Don't know |
| 20. Increase in thirst?.....   | Yes | No | Don't know |

## EXAMINER'S COMMENTS

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# MEDICAL HISTORY

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## CENTRAL NERVOUS SYSTEM

21. Tendency to faint, have convulsions, seizure or epilepsy?..... Yes No Don't know

## HABITS

22. Do you now or have you ever used tobacco products?..... Yes No Don't know

23. How many alcohol drinks do you consume a day?..... Week? Month? \_\_\_\_\_

## MEDICATIONS

24. Are you taking ANY medications now?..... Yes No Don't know

If Yes, please list the prescription drugs and non-prescription drugs.

\_\_\_\_\_

\_\_\_\_\_

25. Have you taken any steroids in the last six months?..... Yes No Don't know

## EYE, EARS, NOSE, THROAT

26. Do you get frequent or severe headaches?..... Yes No Don't know

27. Have you ever had eye, ear, nose or sinus problems?..... Yes No Don't know

28. Do you have difficulty swallowing?..... Yes No Don't know

## GENERAL

29. Are you in good health?..... Yes No Don't know

30. Arthritis (painful, swollen joints)?..... Yes No Don't know

31. Have you ever had an artificial joint placed?..... Yes No Don't know

32. Cancer, chemotherapy or radiation therapy?..... Yes No Don't know

33. Venereal disease (syphilis, gonorrhea, herpes or other)?..... Yes No Don't know

34. A blood transfusion?..... Yes No Don't know

35. Are you being treated by a physician now?..... Yes No Don't know

If Yes, for what condition? \_\_\_\_\_

36. Been hospitalized, had major surgery or been seriously hurt?..... Yes No Don't know

37. Do you have any further questions, concerns or additional information?..... Yes No Don't know

If Yes, please specify: \_\_\_\_\_

38. Are you pregnant?..... Yes No Don't know

39. Physician's name: \_\_\_\_\_

Address: \_\_\_\_\_

## EXAMINER'S COMMENTS

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# DENTAL HISTORY

Please circle the correct response (Yes, No or Don't know); answer all questions. The following questions are for our records only and will be considered confidential information.

1. What is the reason for your dental visit? \_\_\_\_\_  
\_\_\_\_\_
2. Have you ever had any complications following dental treatment?..... Yes No Don't know  
If Yes, please explain: \_\_\_\_\_
3. Are you concerned about receiving dental anesthetic?..... Yes No Don't know
4. Have you ever had a bad reaction to a local dental anesthetic?..... Yes No Don't know
5. Have you ever had a severe injury to your face, teeth or jaws?..... Yes No Don't know
6. Have you ever had surgery in your mouth or on your lips?..... Yes No Don't know
7. Have you ever had radiation treatment of your neck or head?..... Yes No Don't know
8. How many times a year do you get your teeth cleaned?..... \_\_\_\_\_
9. How many times a day do you brush your teeth?..... \_\_\_\_\_
10. Are your teeth sensitive to hot, cold or pressure?..... Yes No Don't know
11. Do you have bleeding gums?..... Yes No Don't know
12. Do you have frequent or recurrent sores in your mouth?..... Yes No Don't know
13. Have you ever had periodontal treatment for your gums?..... Yes No Don't know
14. Have you ever had orthodontic treatment to straighten your teeth?..... Yes No Don't know
15. Have you had a recent tooth ache?..... Yes No Don't know
16. Have you ever had extraction of any teeth?..... Yes No Don't know  
If Yes, for what reason? \_\_\_\_\_
17. Have you ever had root canals (endodontics) on any teeth?..... Yes No Don't know  
If Yes, how long ago? \_\_\_\_\_
18. Do you have trouble chewing?..... Yes No Don't know
19. Do you clench or grind your teeth?..... Yes No Don't know
20. Do you have any difficulty opening your mouth as wide  
as you would like?..... Yes No Don't know

**Examiner's Comments**

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# DENTAL HISTORY

21. Does your jaw click, pop or hurt when you chew? ..... Yes No Don't know  
 22. Please circle the amount of sugar in your diet. .... Large Medium Small  
 23. Does anyone in your family have discolored, misshaped,  
 or missing teeth? ..... Yes No Don't know  
 24. Have you had any missing teeth replaced by a removable denture or  
 fixed bridge? ..... Yes No Don't know  
 25. Are you satisfied with the replacement? ..... Yes No Don't know  
 26. Are you interested in more information about replacements? ..... Yes No Don't know  
 27. Are any of your teeth loose? ..... Yes No Don't know  
 28. Are you satisfied with the appearance of your teeth? ..... Yes No Don't know  
 29. Do you have any further questions, concerns or additional information? . Yes No Don't know

If Yes, please specify: \_\_\_\_\_

30. What is the name of your previous dentist? \_\_\_\_\_

## Examiner's Comments

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*I certify that to the best of my knowledge the above information is complete and accurate.*

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Month Day Year

Examiner \_\_\_\_\_ Date \_\_\_\_\_ Checked by Dr. \_\_\_\_\_ Date \_\_\_\_\_

Review & update of questionnaire Date \_\_\_\_\_ Sig. \_\_\_\_\_

Review & update of questionnaire Date \_\_\_\_\_ Sig. \_\_\_\_\_